

**Reducing opioid overdose deaths in Minnesota:
Insights from one tribal nation**

National Drug Early Warning System (NDEWS) Minnesota HotSpot Study

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Executive Summary

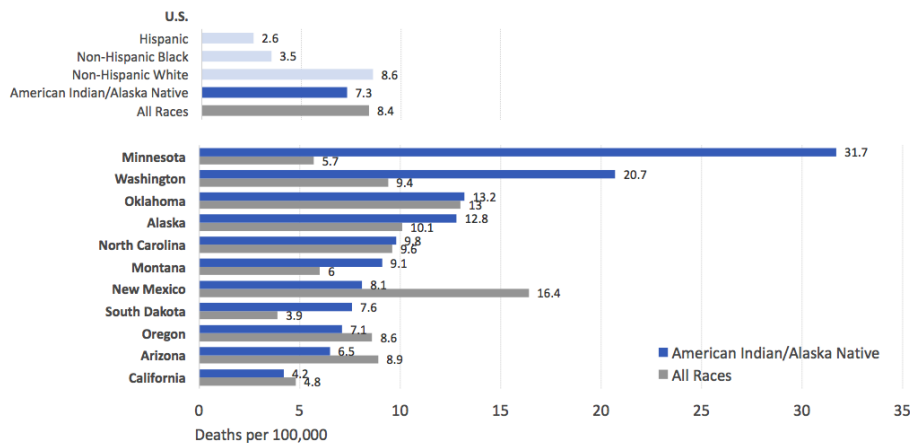
Background: American Indians and Alaska Natives in the United States continue to persist and thrive, but the opioid crisis and opioid overdose deaths are a current threat to health and well-being. American Indians in Minnesota have the highest opioid overdose death rate of American Indians and Alaska Natives in the United States. **Aim:** As one effort to address this, a partnership was initiated between a Minnesota rural tribal nation, Gaa-waabaabiganikaag (White Earth Nation), and investigators at the University of Minnesota Medical School, Duluth Campus, with funding support from the National Drug Early Warning System (NDEWS). These partners embarked on a NDEWS HotSpot study to identify risk and protective factors for opioid overdose deaths for White Earth Nation. **Method:** From January to May of 2019, the HotSpot team coordinated a pilot of overdose fatality review (OFR) and pre- and post-focus groups with the OFR team and community members. Themes pertaining to risk and protective factors for opioid overdose deaths were identified from the OFR pilot and focus groups. **Results:** Five fatality reviews and four focus groups were conducted. Overdose risk factors identified from OFR included (1) hesitation or refusal to call for assistance, (2) lack of coordination with other substance use disorder treatment programs, (3) unaddressed medical and mental health needs, (4) movement between reservations and to urban areas, and (5) poor data accuracy and availability. Risk factors identified from the focus groups included (1) implications of historical loss, (2) historical and contemporary trauma, (3) shame and stigma, (4) effects on children, and (5) jurisdictional issues and rurality. Protective factors identified from the focus groups included (1) innovative solutions, (2) naloxone availability, (3) community collaborations, and (4) culture. **Conclusion:** Opioid overdose death inequities among American Indians in Minnesota and the participating tribal nation have multiple contributing factors that offer an opportunity for intervention. There is a particular need for community involvement, multidisciplinary collaboration, continued naloxone outreach, additional funding for multiple services (e.g., recovery-based housing, mental health, cultural programming, and transitional [reentry] support services), and improving reliability and access of pertinent data.

Background

There are 573 federally recognized American Indian tribes and 5.2 million American Indians and Alaska Natives in the United States (U.S. Census Bureau, 2012). They represent diverse cultures, languages, histories, geographies, and health statuses. Tribal sovereignty means that federally recognized tribes exist in the United States as domestic dependent nations with rights to self-government that include regulatory authority for research processes and policies (Sahota, 2007; Warne & Frizzell, 2014). Similar to tribal nations across the United States, Anishinaabe (Ojibwe) and Dakota American Indians in Minnesota continue to persist and flourish despite decades of colonization, forced relocation, boarding schools, and discrimination (Treuer, 2010). The opioid crisis, however, is a threat to the health and well-being of American Indian individuals and tribal nations.

Data from the CDC National Center for Health Statistics National Vital Statistics System on drug poisoning deaths revealed a striking disparity in 2011–2015 in the rate of drug poisoning deaths involving opioids between American Indian/Alaska Native populations and all groups in Minnesota (Figure 1). In Minnesota, American Indian/Alaska Natives had a rate of 31.7 drug poisoning deaths involving opioids per 100,000 in comparison to 5.7 across all groups (Centers for Disease Control and Prevention, 2017).

Overdose Deaths Involving Opioids, American Indians By State, 2011-2015



Source: CDC/NCHS National Vital Statistics System, Mortality

Figure 1. Opioid overdose deaths by state, 2011–2015. CDC/NCHS NVSS, Mortality

The overall drug overdose death rate for American Indians in Minnesota rose from 2015 to 2017 while staying constant for other groups. It increased from 47.3 per 100,000 in 2015 to 76.2 per 100,000 in 2017 (Figure 2; Minnesota Department of Health, 2018a). In 2018, the Minnesota Department of Health released a report, “Race Rate Disparity in Drug Overdose Deaths,” highlighting drug-related disparities for American Indians and African Americans in Minnesota using a social determinants of health framework (Minnesota Department of Health, 2018b).

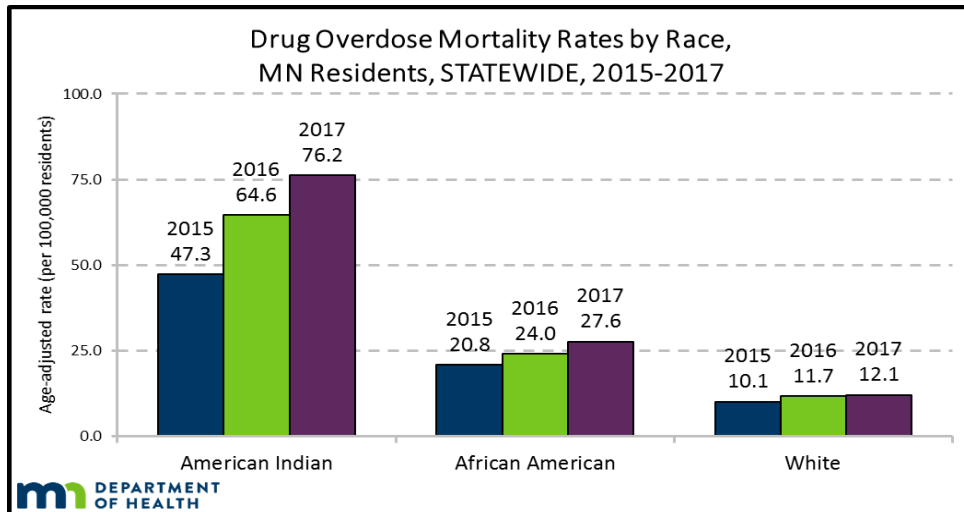


Figure 2. Drug overdose mortality rates by race, Minnesota residents, 2015–2017

American Indians and Alaska Natives and tribal nations in Minnesota (and across the country) were already active in addressing the opioid crisis when this study began, and they continue to address it. Tribal nations in Minnesota have held Tribal Opioid Summits yearly beginning in 2016 and called for government-to-government consultation with the United States on this issue. They also issued public health emergencies (e.g., White Earth Nation in 2011; Red Lake Nation in 2017). One result of these efforts was federal–tribal consultation held in Prior Lake, Minnesota, in May 2018. This consultation was hosted by the Indian Health Service, the Substance Abuse and Mental Health Services Administration, and the National Institutes of Health. Grassroots community-based efforts to address the opioid crisis also are ongoing (e.g., Sober Squad).

The National Drug Early Warning System (NDEWS) Coordinating Center and National Institute on Drug Abuse (NIDA) staff were interested in supporting these efforts by working with researchers at the University of Minnesota Medical School, Duluth Campus, to explore opportunities for utilizing the NDEWS HotSpot approach to develop and pilot Opioid Fatality Reviews (OFRs) with tribal nations. At the 2016 MN Tribal-State Opioid Summit, participants had recommended that the state fund opioid overdose fatality review as a prevention measure. Thus, Gaa-waabaabiganikaag (White Earth Nation), a tribal nation in rural Minnesota, and researchers at the University of Minnesota Medical School, Duluth Campus, formed a partnership to conduct focus groups and pilot the implementation of OFRs. This partnership was supported by funding from NDEWS.

Partnership/Planning Process

Review of Publicly Available Data

NDEWS Coordinating Center staff began working with researchers at the University of Minnesota Medical School, Duluth Campus (UMN-Medical School Duluth; Walls, Gonzalez, and Greenfield) in late 2017 to review publicly available data about opioid overdose and misuse in Minnesota. NDEWS Coordinating Center staff reviewed additional CDC and Minnesota data from the Minnesota opioid data dashboard, Minnesota epidemiological profiles, and DEA

National Forensic Laboratory Information System data for 2012–2017. They also conducted literature reviews and local news scans. The UMN Medical School-Duluth researchers identified additional potential local resources such as the Great Lakes Inter-Tribal Epidemiology Center and reports such as the tribal opioid summit reports and action plans for 2016 and 2017. They also provided background information on tribal nations and research protocols. In February 2018, the UMN-Medical School Duluth team began reaching out to their connections in tribal communities and participants of the 2016 and 2017 Tribal Opioid Summits to determine interest in and focus for such a project.

Site Visit

Erin Artigiani, NDEWS Co-Investigator, and the UMN Medical School Duluth team then prepared a presentation for the 2018 National Tribal Public Health Summit, organized by the National Indian Health Board. The presentation was titled, “Introducing the NDEWS HotSpot Study Opportunity for Assessing Opioid Overdose Inequities in Minnesota.” The presentation was an opportunity for the UMN Medical School-Duluth team and Ms. Artigiani to provide an overview of NDEWS, the resources it offers, and Minnesota relevant data, as well as to listen to the needs and interests of tribal members. UMN Medical School-Duluth researchers also organized stakeholder meetings at the National Tribal Public Health Summit with individuals directly involved in substance-related prevention and treatment with American Indian communities in Minnesota and nationally.

This data review and consultation process continued after the Summit and led to the identification of opioid fatality reviews as an approach for an NDEWS HotSpot study, and to the identification of a tribal partner, White Earth Nation. White Earth Harm Reduction Integration and the White Earth Reservation Overdose Response Committee had been actively seeking a partnership to implement overdose fatality review and had included overdose fatality reviews as a priority in their Tribal Action Plan. They had begun exploring OFR implementation via technical assistance and an in-person training in May 2018 from Erin Russell (one of the report authors) through the Center for Applied Prevention Technologies, a SAMHSA technical assistance provider. The UMN-Medical School Duluth investigators prepared a proposal in partnership with White Earth Nation and received a subaward from NDEWS to pilot opioid overdose fatality review as a way to identify contributors to opioid overdose deaths.

The HotSpot Study Team

Gaa-waabaabiganikaag (White Earth Nation)

White Earth Nation is an Anishinaabe nation in rural northwestern Minnesota. The counties where it is located have had the highest rates of youth prescription drug misuse, drug poisoning deaths, and per capita opioid prescriptions (MN Department of Human Services, 2017). White Earth Reservation Overdose Response Committee and White Earth Harm Reduction Integration Program developed a data-driven prevention strategy for overdose fatalities that included making buprenorphine and naloxone available and introducing harm reduction services such as needle exchange and prearrest diversion strategies.

University of Minnesota Medical School, Duluth Campus (UMN-Medical School Duluth)

The mission of the University of Minnesota Medical School, Duluth Campus, is to be a national leader in improving healthcare access and outcomes in rural Minnesota and American Indian/Alaska Native (AI/AN) communities. This is done by educating medical students dedicated to serving rural Minnesota and American Indian/Alaska Native communities, fostering excellence in research, emphasizing the training of physicians in Family Medicine, creating strong partnerships locally, regionally, nationally, and internationally, as well as working in innovative, interdisciplinary, and interprofessional teams.

National Drug Early Warning System (NDEWS)

The National Drug Early Warning System (NDEWS) is an NIDA/NIH-funded substance use and misuse early warning system and coordinating center that supports collaborating local experts and practitioners to generate critical information about emerging drugs and their public health consequences. Collaborating experts, practitioners, and NDEWS staff work together on HotSpot studies to explore specific drug trends in specific geographic locations via a rapid investigation. NDEWS has also sponsored HotSpot studies in New Hampshire, Ohio, and Oregon.

Project Aims

This HotSpot Report is about one tribal nation’s creative and innovative strategies to address an emerging issue of national concern—the opioid crisis—at the local level. The goal of this HotSpot study was to identify factors that may contribute to these deaths and provide recommendations about ways to address these factors, with the ultimate goal of reducing opioid overdose deaths and health inequities.

The specific methodology used to identify risk and protective factors was Overdose Fatality Review (OFR) and focus groups. During the course of this HotSpot, the partners completed a pilot of OFR along with a total of four pre- and post-focus groups with OFR team members and community members. The following report describes specific findings from the OFR pilot and the focus groups on risk and protective factors for opioid overdose deaths for White Earth Nation. These findings may be particularly useful for other tribal nations and rural communities.

Method

After forming a partnership, the HotSpot team obtained a research permit from the White Earth Research Review Board prior to beginning this study. The University of Minnesota Institutional Review Board deemed this project exempt from ongoing review.

Overdose Fatality Review Pilot

Overdose fatality review involves bringing together a multidisciplinary group of individuals to share data, identify contributors to overdose deaths, and use this information to make changes and prevent future overdose deaths (Rebbert-Franklin et al., 2016). Tribal partners recruited OFR team members, coordinated meetings, and obtained necessary legal and regulatory approvals to implement OFR. This included obtaining a tribal resolution to support the OFR process and allow data sharing among OFR team members.

Prior to the start of any fatality reviews, co-author Erin Russell provided technical support and training to those leading OFR program implementation and team members. Training of OFR team leadership involved a 4-hour in-depth overview of OFR, how to run effective case review meetings, data collection processes, and policy and program considerations. Team members received training on OFR principles, confidentiality, and expectations. Finally, Erin Russell also worked closely with the research team to develop forms and procedure documents and participated in biweekly calls to discuss challenges, problem solve, and give guidance as needed.

The Minnesota Department of Health provided a list of cases uploaded to a secure, HIPAA-compliant Box site maintained by the UMN-Medical School Duluth team. Inclusion criteria included (1) drug overdose as underlying cause of death (ICD-10 codes: X40-X44, X60-X64, X85, Y10-Y14), (2) opioid (Contributing Cause of Death ICD-10 codes: T40.0-T40.4, T40.6) or multidrug toxicity as contributing cause of death (Contributing Cause of Death ICD-10 code: only T50.9), (3) deaths between 2014 and 2017, (4) residence in Clearwater, Becker, or Mahnomen county, and (5) American Indian.

From 2014 to 2017, there were 12 cases that met the above criteria. When the OFR process was beginning (January 2019), four of these cases (33%) still had legal investigations pending (per review by tribal law enforcement) and were not available for review. This left eight possible cases for review. The HotSpot team initially selected cases to achieve age and gender representation; as the OFR pilot progressed, they selected more recent cases because of better availability of health records. Ultimately, five cases were reviewed during the pilot. Originally, the OFR team had planned to review more, but the team needed additional time for adequate and respectful discussion of each case at the OFR meetings.

The OFR team consisted of representatives from the following tribal programs: public health, substance abuse, MAT, ambulance services, behavioral health, mental health and crisis response, and cultural programs. Law enforcement was not present at the review meetings but provided arrest records. All team members provided an alternative representative, signed confidentiality agreements, and completed an OFR orientation prior to the first review. The tribal OFR coordinator sent out case names and date of birth via secure email prior to the OFR. Team

members then completed a case report form specific to their agency that summarized pertinent details (e.g., arrests and ambulance runs). OFR team members also brought any records (physical or electronic via laptop) to the OFR meeting. A UMN Medical School-Duluth team member reviewed publicly available Internet/social media and corrections records and prepared a one-page summary of the death certificate data for the OFR meeting. The tribal medical director reviewed the death certificate data in advance to provide any needed explanations of medical conditions or terms.

At each review, data included the following when available: death certificate data, corrections and online social media reviews, and records from each representative (e.g., ambulance runs and treatment records). Team members could also share any personal knowledge they had of the individuals. The primary purpose was to respect the spirit of the deceased, aligning case review procedures with cultural practice. During the OFR, team members identified ways to prevent future overdose deaths at different levels (systems, organizational, etc.), as well as needed data or information to inform prevention efforts. In sum, meetings included the following steps: (1) opening; (2) summary of death certificate data; (3) summary of online/social media and corrections data, leading with the individual's strengths; (4) review of each agency's records; and (5) discussion of factors that may have contributed to the individual's death and recommendations to prevent future deaths. There were 14 participants at the first meeting, nine participants at the second meeting, and eight participants at the third meeting. Mental health staff were also on hand to provide support for any OFR team members due to the nature of the discussions.

Focus Groups

Four focus groups were held within the reservation community: two groups with OFR team members, and two groups with community members. Two were held before the start of the OFR pilot, and two were held after the conclusion of the OFR pilot. The focus groups lasted from 60 to 90 minutes, and the number of participants in each ranged from four to seven individuals. HotSpot team members recorded and transcribed each focus group.

The overall goal of the focus groups was to understand perceptions of the OFR process (risk and benefits) and their cultural fit; only preliminary information on this aspect of the project is provided here. This HotSpot report focuses more specifically on risk and protective factors for opioid overdose deaths. Several questions (described below) focused on risk and protective factors, and the transcripts were reviewed for discussions of these factors. Relevant quotes were grouped into themes by the HotSpot team. We re-engaged the focus group participants to review thematic findings, and one participant requested slight changes to his contribution; the general findings did not change as a result.

Overdose Fatality Review Team Focus Groups

All members of the overdose fatality review team were invited to participate in the pre- and post-focus groups. Participants received a meal and a work-related incentive (e.g., padded notebook). The pre-focus group included six participants. It occurred directly after the OFR orientation. It was held to assess members' perceptions of fatality reviews and expectations of the process. It included questions such as "What parts of the fatality review meetings do you think will be especially helpful? From what you know about OFR so far, what fits from an anishinaabe perspective? What could be changed to better fit with cultural values and traditions?" It also

included one question specifically about vulnerability factors (“What do you think makes the community vulnerable to overdose?” see Appendix A).

The post-focus group included eight participants. It occurred directly after the third OFR and included questions to collect information about what OFR members found most useful about participating in the OFR, what could be improved or changed, and whether the participants felt the OFR process should continue. It did not include specific questions about overdose vulnerability or protective factors; questions were focused generally on next steps and adaptations of OFR in a tribal setting (Appendix B).

Community Focus Groups

Tribal research team members identified participants for the community focus groups who lived on the reservation, were not directing tribal programs but had community leadership positions, and/or were active in addressing the opioid crisis. Participants received a meal and \$30 at each focus group. The pre-focus group included five participants and was held before the OFR pilot began. It was held to collect participants’ perceptions of the benefits and challenges in conducting OFRs and who to include on the OFR team (Appendix A). There were also two specific questions about risk and protective factors (“What are some of the protective factors that are here that protect people against overdose?” and “What do you think makes people vulnerable to overdose here?”).

The post-focus group included four participants. It began with a presentation about OFR and the overall findings of this OFR pilot. Participants were asked to share their thoughts on OFR, and what they thought should happen next with OFR (Appendix B).

Results

Opioid Overdose Fatality Review Pilot Results

Case Demographics

The OFR team reviewed five cases over the course of three team meetings between March and May 2019. All cases reviewed were American Indian adults who had no pending tribal legal investigations. Three were male and two were female, with an average age of 33 years. All died accidentally of drug-related causes, with opioids involved. Deaths occurred between 2015 and 2017. The death certificates listed all individuals as living at a residence in one of the counties where the reservation is located. Three of the five died at hospitals, and two died at private residences; four had autopsies.

Key Themes

Using the OFR process described on pages 7–8, team members identified the following five factors or circumstances (themes) that may have contributed to the deaths that the OFR team reviewed. These themes represent areas that could be addressed or changed for prevention of future overdose deaths.

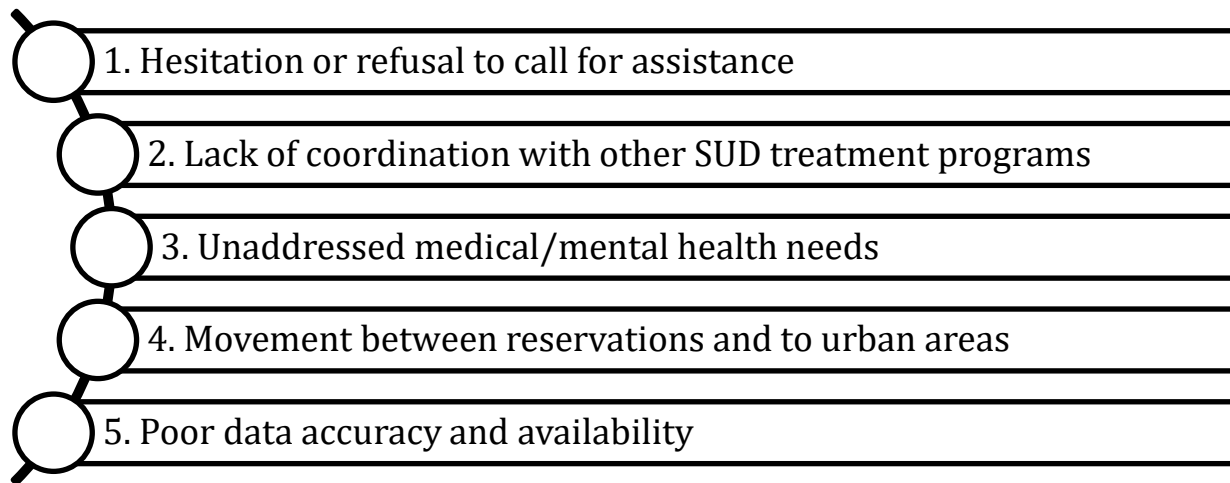


Figure 3. Five main themes identified during tribal OFR pilot.

1. Hesitation or refusal to call for assistance

For one case, there seemed to be a large gap in time between the overdose and when ambulance services were called. This delay may have contributed to the individual's death. The team thought that this may have been a result of fear on the part of those present at the scene about potential legal consequences. Confusion about the specifics of Good Samaritan laws and/or lack of awareness of their existence may cause uncertainty and could decrease the likelihood of seeking emergency assistance in the case of opioid overdoses.

2. Lack of coordination with off-reservation/non-tribal SUD treatment programs

For one case, the OFR team knew the individual had gone to an off-reservation treatment program in the year prior to his or her overdose death but did not have information about when that person discharged or a summary of treatment progress. The team also felt unsure if the off-reservation program offered culturally appropriate care and adequately met the needs of American Indian clients.

3. Unaddressed medical and mental health needs of individuals using opioids

In another case, the issues of providing comprehensive care for other medical conditions were highlighted. The individual had another medical condition for which he or she may have been prescribed opioids but could have benefited from nonpharmacological treatment options. In this case, the need to make medical and holistic care easily available for individuals using opioids was emphasized, as well as the need to make non-opioid options available to those with chronic medical conditions. Team members discussed how it can be easy to focus solely on drug use in settings like substance use treatment programs or harm reduction clinics, but mental health and other medical needs also need to be identified and treated in an ongoing manner. Stigma and shame may also prevent individuals using opioids from being completely transparent when seeking healthcare services.

4. Movement between reservations and to urban areas

Individuals from other tribal nations reside on the reservation because of work, friendship, and relationships. Primarily driven by the Indian Relocation Act of 1956, many American Indians also grew up in urban areas like Chicago, Minneapolis, or Los Angeles outside of their home tribal nation and have social ties in multiple locations. The cases reviewed moved between White Earth Nation and other locations for family and employment, or vice versa, and consequently changed engagement with healthcare and social systems. Therefore, service gaps were created as individuals navigated new care options, treatment programs, and resources. In addition, the team noted how social ties within a community were challenged with transience. Connectivity was often lost, which may contributed to risk of overdose deaths.

5. Poor data accuracy and availability

The OFR team had death certificate data for the review process, but they did not have toxicology reports or autopsy reports that might have provided more specific and accurate data about the reasons for overdose. Records from hospitals or off-reservation programs also were not available, reflective of the problems associated with this itinerant population and fragmented systems of care. Because of a recent switch from paper to electronic health records, records from tribal services were also limited. The team also wondered about the accuracy of the death certificate determinations as some seemed vague, and there was some concern whether these deaths might have different causes but were written off as “another American Indian drug-related death.” All in all, more comprehensive data collection on deaths and access to additional records would improve the OFR team’s ability to draw precise conclusions and make recommendations.

Focus Group Results

Perceptions of the OFR Process

Analysis of focus groups results are ongoing. Preliminary results regarding perceptions of the OFR process indicate that many OFR members found the process to be a valuable resource for understanding opioid overdoses. Parts of the process that were found to be most beneficial include seeing the strengths of those who were lost and taking time to come together and reflect on ways to improve systems and recognize the progress in addressing overdose deaths that the community has made.

The members felt that the OFRs should continue and might be useful for other tribal nations. Modifications were recommended such as reconsidering the frequency of meetings, allowing more time for reviewing each case, and refining the criteria for selecting cases. Other recommendations included involving representatives from other organizations such as the Indian Health Service or local hospitals, requesting records from facilities or groups relevant to particular cases (e.g., medical records from the hospital where a death occurred), and involving family members and/or community members in the OFR process.

The remainder of this section will address risk and protective factors related to opioid overdoses identified in the focus groups.

Risk Factors for Opioid Overdose Deaths

Five major risk factors for opioid overdose deaths were identified by OFR and community focus group participants (Figure 4). These themes are described in further detail below and aggregated across the four focus groups. Quotes represent individual opinions of the participants.

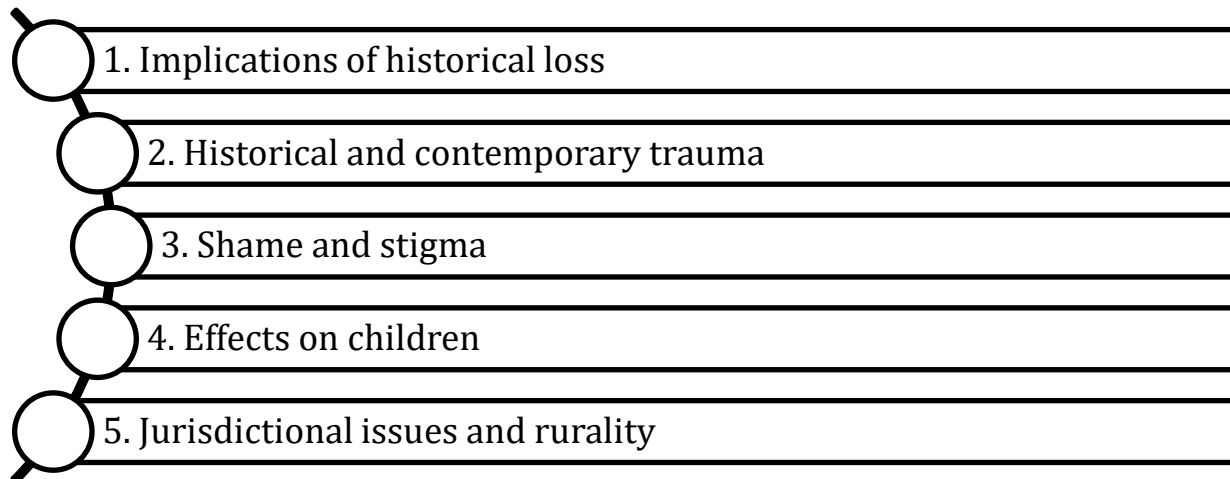


Figure 4. Five key themes identified during community and OFR team focus groups.

In addition to these five themes, there was concern regarding the accuracy of the death certificate classification of opioid overdose deaths. Participants said:

What are the circumstances that are actually around their death? They just didn't OD and die. There are rumors, there have been rumors, so I would say you need to investigate their actual deaths.... Did they not even do, you know, an autopsy to really determine the death or just assuming that oh, it's just another Indian with a needle in their arm, OD. And not bother. [Community focus group participant]

I want to know more on the cases where determined to be overdoses and it seems like there's obviously foul play, I mean a few years back I know there was a few cases that were questionable, like okay, yeah, they were high when they were doing it but what happened? [Community focus group participant]

This issue complicates tracking and prevention of opioid overdose deaths. It also highlights stereotypes or biases about drug use among American Indians that may exist.

1. Implications of historical loss (culture/language/practices)

Prior to the passage of the American Indian Religious Freedom Act in 1978, the 1883 Code of Indian Offenses criminalized American Indian traditional dances, marriage/divorce, burials, social gatherings, and more. The code and its enactment by the U.S. government outlawed traditional practices and made them punishable by law. The legacy of this cultural suppression was evident in participants' comments:

My grandparents were not brought up traditional and my mother and uncles struggled with cultural identity. My grandmother went to church while my grandfather went to ceremony and disliked the idea of a Native person practicing a colonizer's religion. I remember when I attended my first ceremony and my grandfather told me not to tell people about ceremony. I feel there is a multi-generational stigma on how Native people are supposed to practice their religious beliefs. There is always a certain way to do something, yet everyone does it differently. This causes confusion and loss of teachings. [Community focus group participant]

Another participant highlighted a need for more community members to lead traditional practices:

What is culture to our people? They don't know. They don't know what our culture is. Because they got caught up in the drug culture. All these other cultures that are out there, hip-hop culture, there's a whole bunch of cultures, different cultures and what is culture to our people? They don't know. So that's what I'm finding out and what do they want to know? What do they want to learn? So in getting people together. I do sweats and it's hard, I get burnt out, like going here, going there, to run sweat, you know it's like, oh I need help, I need help. And there's not people stepping up. Not people stepping up too, that's a big vulnerability because there's not people available or that are willing to help. And that's a big aspect, sweat's amazing, it helps a lot of people, but there's not people that are stepping up in our communities. [Community focus group participant]

Focus group participants saw culture as a vehicle for healing and substance use prevention (see also the “Protective Factors” section below). One participant commented on the ongoing process of programs incorporating culture:

There’s that whole laundry list of things, adverse childhood experiences, lack of social economic status, multi-generational dysfunction, behaviors, you go through all those. I think one of the deeper issues is, we think of our approach to substance misuse over the years, some of the failed policies and things like that. I think that whole list is not withstanding, I think it’s there, but I think for us what makes us vulnerable is I don’t think we’ve done enough to strengthen cultural identity and draw on cultural resiliency of our families. I think we’re doing it now. I think for a long time we struggled, “well we just need to get culture in there,” and a lot of professional programs really struggled with, well what does that mean, does that mean slapping a feather on our logo? Does it mean smudging at the beginning of all our events? Symbolic things, but really that vulnerability is that we haven’t, I don’t think we’re there yet, I don’t think we’ve gone far enough to reconnect back to those cultural ways to strengthen our family with all of this, all these other issues that have already been touched on. [OFR team member focus group participant]

2. Historical and contemporary trauma have significant implications for prevention

The opioid epidemic has brought to light interconnected issues that community members indicate have increased dramatically in recent years. The interconnected issues of historical and contemporary trauma in tribal communities highlight the complexity in finding the right balance between punitive approaches by law enforcement, treating addiction and trauma, harm reduction strategies, and supporting community members affected by others’ drug use. In general, American Indians have high rates of exposure to trauma, and this has been connected to other behaviors such as drug use and sexual risk-taking (Simoni, Sehgal, & Walters, 2004). Participants highlighted this link, discussing trauma as the underlying cause of opioid overdose for many:

The death certificates saying that these people died of overdoses, but it’s not, it’s not, most of them, I’d say 90% died of broken hearts. ... it’s the trauma that our people go through. It’s all the deaths, the losses, that our people face, and this is working on the front lines, seeing this stuff firsthand, and I’m trying and doing my best part what I can do for my people that I work with, and trying to get to the bottom of their addiction that became something, something that became an addiction. Because that first initial hit of that drug, it numbed that pain that they felt. [Community focus group participant]

Trauma came in multiple forms, including sexual violence and sex trafficking, with drug use compounding these issues. One issue that resonated for members in tribal communities was how some individuals who use drugs support their addiction with activities such as sex trafficking, especially that of children:

This is not a new thing, it’s been here for a longtime, so we need to start looking at that type of victimization. I mean we want to help the people where they’re at, but at the same time we need to be looking at the children and what’s causing future trauma and future drug users and future OD victims. [Community focus group participant]

Additional trauma can exist for children who have family members who use drugs. They may witness a family member overdose or fear removal from their families:

I didn't expect, I just had somebody pull up, "c'mon, we need to go," and jumped in. First time seeing this stuff, it was unbelievable [referring to opioid overdose/naloxone administration]. It's the babies or the kids that were there. "Don't call ICW [Indian Child Welfare], don't call the cops, don't call the cops. I don't want ICW to come take us. Please don't call the cops." And you know, that just hurt bad. [Community focus group participant]

Community members also may experience trauma as a result of others' drug use:

But yes, we need to be helping the people who are OD'ing and dying, but at the same time we need to be responding to the community members that are being robbed, that are being abused, that are being victimized. [Community focus group participant]

Healing services, mental health services, and general support were seen as critical to ending cycles of trauma:

I have responded to an overdose where I know this woman. Her grief was so great, her broken heart was so sore, so hurt, that she continued to use and that was never dealt with, that was never helped. She needed help as far as mental health, as far as healing her heart and helping her with her grief. Like right off the bat. If we could have just given her the opportunity to start to heal them wounds that were there instead of you know, you have the Rule 25s [assessment to determine placement and coverage for substance use treatment], great, getting into the [name of treatment program] or getting into the program is great, that's one step, but then going into healing and helping right off the bat, not waiting for a rule 25 to come in. And then saying this person needs this care first before we can start working on that. ... And the continued deaths, deaths after death, after death, the continued overdose after overdose after overdose. Seeing that and knowing that their hearts were broken. It was hard for me to say, you know, I couldn't come to terms to say they died of an overdose, 'cause it was hard. I said no, they died of a broken heart. And that's a lot of our people, they die with broken hearts because that drug numbed their pain. And they just kept hurting and hurting more and more and that drug just kept, it made their tolerance, they needed more to keep that heart numb, to keep that stuff down. And then pretty soon that fatality came. [Community focus group participant]

3. Shame and stigma

A third theme revolved around the shame and stigma individuals using drugs (and their families) felt about their drug use. This shame and stigma, manifested across multiple levels, has implications for individuals seeking supportive services, and it amplifies existing barriers to treatment and recovery services. At the community or family level, individuals using opioids may not disclose drug use because they are embarrassed or don't want to be judged:

Our people are so private about shit that happens to them, they don't want people to know, they don't want that they're struggling, or that their family member had an overdose, or they had an overdose. They're ashamed of it. [Community focus group participant]

When someone has an overdose, that person or those around him or her may not call for help because of stigma and shame or lack of trust in institutions:

I think as a general rule they don't call. Most people do have the Narcan now, which is a benefit, you know, by far, but the majority don't call. I think the most calls we've gotten are from people who, a nurse, substance abuse worker, you know. The person showed up at their place knowing they had the Narcan and that they were the ones that called, but not anybody else. It's, they just don't trust enough, you know. We've got to, as a community, as a tribe, build that trust back up. That's what we're supposed to be. It takes a village, right, you know. [Community focus group participant]

Similarly, individuals using opioids may have avoided seeking medical or mental health care because they were treated poorly in the past or were worried about poor treatment:

How many times have they reached out for services? Follow up on how they were treated. When we were first started doing the harm reduction of clean needle exchange, I had a woman who brought in another woman and she kept her head down and she would steal glances at me. And she goes, oh what do you need, you need this, you need condoms, you need this, you need this, just happy-go-lucky, and she goes, "You were right. She is different." "What do you mean?" "You don't shame me." You don't shame me. We need to stop shaming our people. They've been shamed enough. They already feel the shame for what they're doing. They feel ashamed because they were raped, they feel ashamed because they were victims of domestic violence, they're ashamed because they're homeless, they're ashamed because they're using drugs. Stop shaming our people. That's a vulnerability. [Community focus group participant]

Another focus group participant reflected on the necessary ingredients for healing:

I think that we will probably see some version of something a patient once said to me that made me smile and then shocked the hell out of me. The patient said, you know, you really helped me, doc, but not on the days you thought you were helping me. So I think that we will see that shelter, food, respect, and compassion are gonna turn out to be very important factors in places where healing, help could have been offered. You know, I've thought about that statement for a long time and I think basic needs, respect, and compassion come in pretty important in connecting with people. And helping them to trust in the help you're offering. [OFR team member focus group participant]

4. Vulnerability of American Indian children exacerbated by multiple factors—overburdened/complicated Indian Child Welfare System and multigenerational drug use (normalization)

Focus group participants emphasized the need to support children and youth to prevent future drug misuse or overdose. Availability and access to treatment or supportive services that focus on the entire family are limited or nonexistent in many rural and tribal communities. In Minnesota, American Indian children have out-of-home placements that are 18.5 times greater than those for white children (Minnesota Department of Human Services, 2018). Many out-of-home placements are because of substance use. This extends a history of forcible removal of

American Indian children from their families by the U.S. government and placement in boarding schools. The 1978 Indian Child Welfare Act was created to address disproportionate rates of out-of-home placements with non-American Indian families, but “for most of its history, ICWA has lacked an official oversight agency at the federal level, a national data collection apparatus, and an enforcement authority. As a result, compliance with the law has been uneven at best” (National Indian Child Welfare Association, 2019). The federal government and states have not provided adequate funding to support ICWA, thus, not leaving adequate resources for families facing separation. Several participants highlighted this theme:

What about did they have access to legal representation for whatever legal issues that they may have had? There are a lot of our people who don't, especially with ICW [Indian Child Welfare] cases. Nobody's there to defend and protect their rights, advocate for these babies. [Community focus group participant]

Another vulnerability is that we have over 18,000 members and we have about 30 case workers down in ICW and we have to service those members. Not only in White Earth, not only in Minnesota, but in all of the 50 states wherever our members reside. So I think that's a vulnerability. [Community focus group participant]

Stress is a known risk factor for return to drug use and increased substance use, and one participant described how trauma and stress were precursors to their own substance use:

I go back to when I was a kid. I didn't know I was grief stricken. I didn't know what grief was, I didn't know what it meant. But I was angry. I was all these different emotions and I didn't know how to deal with them. I didn't know how, I started smoking weed when I was really young to numb that pain. And seeing these kids young, young ones, smokin' weed to numb that, to numb that pain. And then going into bigger drugs as [they are] getting older. Getting introduced to these other drugs, getting introduced to these other drugs, and that continuous cycle. [Community focus group participant]

Other participants highlighted the normalization of drug use among families and the visibility of drug dealers:

The lifestyle that some of the families live continues, is passed down. Some kids and young adults, they just feel like it's normal life, they can just sit right in front of their families their parents and use, grandparents, and I just think they expect it to be a common thing. [OFR team member focus group participant]

All the kids know who the drug dealers are. [Community focus group participant]
Every place I can go, can point out, they deal there, they deal there. [Community focus group participant]

Finally, disproportionate rates of incarceration of American Indian youth also was seen as a driver of trauma and future drug use:

Juvenile detention facilities, how many of our youth are being locked up? They're not bad. They're living in massive traumas and they don't know how to deal with it. They're either acting out, they're angry, turning to alcohol and drugs for self-medicating, or they're hurting other people. We should be looking at what's going on with them instead of locking our children up. I do believe that in the State of Minnesota, we are what, 1% of the population or 1.5% and 57% of the Native American youth represent juveniles in detention facilities in the state. I mean does anybody even keeping track of how many of our children are in there? Have they come home? How many children are missing from those detention facilities, how many are missing from group homes? Because they do run away. [Community focus group participant]

One participant offered a path forward by explaining that overdose prevention begins by taking care of the health and well-being of children:

If we can conquer the mental health of our people, then that reaction, the stuff wouldn't be there, I mean, it would be minimal, very minimal usage with our people. With our kids that are growing up with all this trauma and seeing it in schools, knowing a lot of our kids have seen and dealt with trauma at this early age, our teenagers that have dealt with this, so if we're not dealing with these kids right now, all that mental health stuff is going to turn into an addiction sooner or later because they don't know how to process. So, really looking at that as some kind of overdose prevention, because if these kids don't start to deal with their mental health, we're going to have another generation of a lot of addiction, because our kids are seeing a lot and have dealt with a lot, seeing their parents OD, seeing their family members dying. [Community focus group participant]

5. Jurisdictional issues and geographic spread/rurality

Geographical distance presents challenges in responding to overdose by first responders in addition to the provision of treatment or recovery services. This is further complicated within the complex jurisdictional issues that exist among county, state, tribal, and federal agencies working to address overdose fatalities. One participant said:

We have a hard time out there, though, because the ambulances and stuff that respond to [village] are from [small town], they're [urban hospital several hours away]. They're not tied in with tribal ambulance. So like a lot of our overdoses and stuff aren't reported. Because they're going to [name of urban hospital several hours away] instead of the tribe. [Community focus group participant]

The degree of cooperation and collaboration between agencies can also dictate response effectiveness. White Earth Nation's large area and rurality complicates quick and effective responses to opioid overdoses, and poverty can compound these issues:

Another disadvantage is that our communities are so far spread apart. It's hard for people to get services because of the distance and the transportation. Not everyone has or can afford a car. The public transportation system isn't enough if you need to travel past 7:00 pm or on weekends. Even our emergency services struggle with the distance and that's a scary thing knowing an ambulance might not get you to the hospital in time or even get to you at all. [Community focus group participant]

Finally, these jurisdictional complexities can make prosecution of individuals selling drugs challenging:

From the outside looking in, there are people out there that see the vulnerability of the communities and come in and take advantage of that. And that's one of the bigger things too, but it all comes together and we have a couple committees that we're working on to combat a lot of the economic development stuff, a lot of the vulnerability stuff and a lot of the stuff that we can combat to stop it from happening. [OFR team member focus group participant]

Another vulnerability would be us being on a reservation. Dealers are hard to catch because of jurisdiction issues and lack of community cooperation with law enforcement. There have been efforts in community policing, starting multi-jurisdictional collaborations. [Community focus group participant]

Protective Factors that Reduce Overdose Deaths

In the face of the risk factors described above, White Earth Nation continues to draw on its strengths and resilience to prevent opioid overdose deaths. Such strengths are often referred to as “protective factors,” which Walker and colleagues (2011) described as variables that neutralize or weaken risk factors. Four major protective factors were identified via the focus groups:

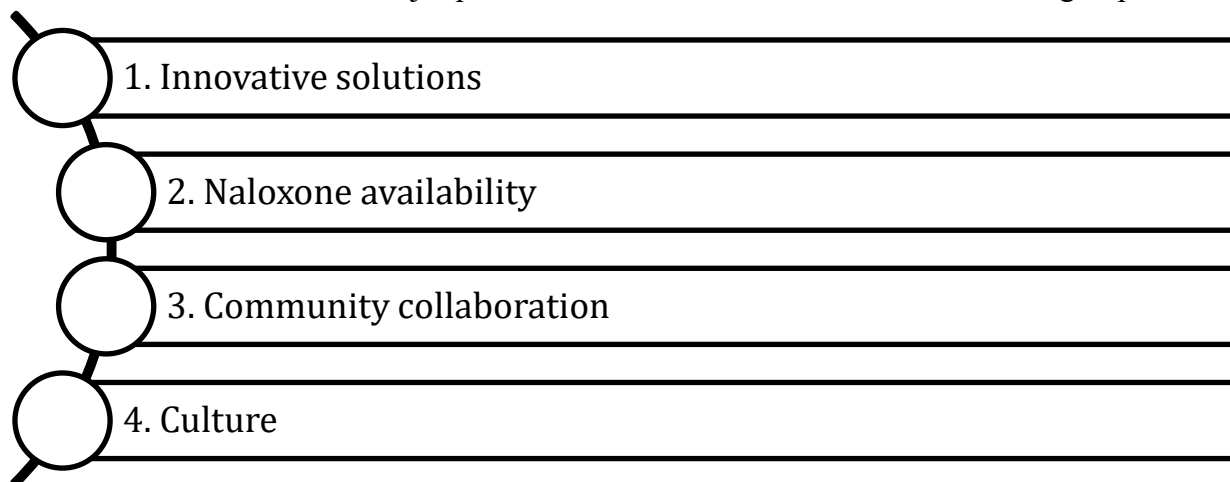


Figure 5. Four protective factors identified during focus groups.

1. Innovative solutions | Existing sources of resiliency

Community members and tribal employees are well aware of the opioid crisis and have been moving forward with new programs and ideas to address opioid misuse and overdose deaths. One participant described how these solutions need to be community led and optimized for tribal settings:

There's a lot of community strengths and the fact that we're actually still here, we survived genocide, we are very much a resilient people. We are intelligent, we are caring, and we are loving, and we're always coming up with solutions to find what's going on and try to respond to what's happening within our communities. We know what our problems are and we as

community members know what those solutions are. All too often we have too many Western programs trying to come in that don't fit. They don't fit standard rest of the United States, why would it fit here, tribal communities which are very distinct and different. [Community focus group participant]

Another participant further expanded on local innovation:

A lot of programs that we are developing, and tweaking are helping break the stigma of finding help, whether it's mental health or substance abuse. The police department is implementing community policing and getting familiar with Good Samaritan laws. Programs are hosting community picnics while offering services. Having an overdose prevention officer that goes out on calls and offers services is unique and shows what kind of direction we are taking on substance abuse, five years ago that idea would seem crazy. When programs started reaching out to the community the number of overdoses decreased significantly. [Community focus group participant]

2. Naloxone availability | Overdose prevention and effective naloxone distribution

In line with national pushes to increase naloxone availability as a direct antidote to opioid overdose (e.g., the U.S. Surgeon General's Advisory on Naloxone and Opioid Overdose), White Earth Nation has prioritized making naloxone more easily available:

When ODs are happening there's notices on Facebook from the tribe saying they're here, we're handing out Narcan, all of these different things. They're available for coming into communities and into programs, wherever, to provide Narcan trainings and to distribute Narcan. Lots of awareness, lots of education. [Community focus group participant]

3. Community collaboration | Grassroots efforts and the impact of social capital

White Earth Nation is a rural and tight-knit community; tribal community members are working on this problem together. Opioid use and overdose have directly affected almost all community members. There is pain and hurt associated with use and overdose deaths, but many community members are also drawing on compassion and caring for each other (cultural values) to move forward to find solutions:

It does take love, it takes compassion, it takes understanding and a lot of our people are starting to learn that. Because we all have it in us. We all have it in us, and our mission, that the Creator gave us, is helping our people, and there's a lot of people that are stepping up, which is a big, the biggest strength in the stigma, you know, working on the stigma of the overdoses, working on stigma of being on the MAT program, the stigma of the addiction, so it's, lot of people are stepping up and seeing that is amazing. [Community focus group participant]

4. Culture | Prevention and healing guided by traditional wisdom, values, and practices

Reframing contemporary strategies to address substance use and misuse is a critical component of an effective approach for tribal communities. Integrity and courage were seen as essential to healing and overdose prevention, including traditional ceremonies and language restoration:

We have our culture. We have our revitalization and restoration of our language, our ceremonial practices. ... and the other part is our humor. It is the cornerstone of healing. We can laugh at some of the most atrocious things and people may think we're insane but we have an incredible sense of humor. [Community focus group participant]

Summary and Next Steps

The opioid crisis is a current threat to American Indian health, yet American Indian tribal nations are resilient and determined. In Minnesota, American Indians have five to six times the opioid overdose death rate of other groups—the largest such disparity in the United States. Tribal communities are actively taking steps to address this issue. This report summarized findings from a HotSpot study funded by the National Drug Early Warning System (NDEWS) that involved a partnership between Gaa-waabaabiganikaag (White Earth Nation) and the University of Minnesota Medical School, Duluth Campus. The HotSpot study had two aims: (1) identify risk and protective factors for overdose deaths in the partnering tribal nation, and (2) determine acceptability and needed adaptations of OFR in a tribal setting. This report focused primarily on risk and protective factors for overdose deaths by summarizing the results of the OFR pilot and four accompanying focus groups. Details about the implementation of OFR and recommendations for other researchers and tribal nations considering OFRs will be discussed at a later date.

An overdose fatality review brings together a multidisciplinary group of individuals to share data, identify contributors to overdose deaths, and use this information to make changes and prevent future overdose deaths (Rebbert-Franklin et al., 2016). From March to May 2019, five opioid overdose deaths were reviewed over the course of three OFR meetings, and four focus groups were held (two with OFR team members, two with community members). Overdose risk factors identified during OFR meetings included (1) hesitation or refusal to call for assistance, (2) lack of coordination with other substance use disorder treatment programs, (3) unaddressed medical and mental health needs, (4) movement between reservations and to urban areas, and (5) poor data accuracy and availability. Risk factors identified from the OFR team and community focus groups included (1) implications of historical loss, (2) historical and contemporary trauma, (3) shame and stigma, (4) effects on children, and (5) jurisdictional issues and rurality. Protective factors identified from the focus groups included (1) innovative solutions, (2) naloxone availability, (3) community collaborations, and (4) culture.

OFR provided valuable insights into the risk factors contributing to opioid overdose deaths in White Earth Nation and helped highlight important protective factors. The process reinforced the importance of primary prevention strategies that address social determinants of health and the development of interventions that focus on resiliency and protective factors that are found with traditional Indigenous culture. HotSpot findings were presented to OFR team members and community members. Overall, they felt that OFR was beneficial and would be worth continuing. They also recognized the need for expanded services and interventions.

Recommendations to Prevent Opioid Overdose Deaths

These recommendations stem from the HotSpot study findings and input from community and OFR team members after reviewing the HotSpot findings.

1. Address trauma and mental health

Experts have acknowledged that more needs to be done to address the root causes of addiction such as complex trauma. For tribal communities, it is imperative that cycles of trauma be a primary focus in their effort to realign strategies from a reactionary approach toward primary prevention strategies. This includes creating trauma-informed systems of care that include

community, schools, programs, and families, providing grief groups, mental health services, and ways for people to heal their spirits, and building on and improving mental health services.

2. Prevent future drug use

Taking care of children who are exposed to trauma and taking care of their mental health needs was identified as paramount. This could include drug prevention programs in the schools and offering school-based mental health services.

3. Address hesitation to call for overdose assistance

This has multiple components. It could include a communications campaign about how to respond to an overdose, including staying with someone in the event he or she needs an additional dose of naloxone, and education about Good Samaritan laws. It also involves building trust between service agencies and the public so that they feel comfortable calling for assistance. Current harm reduction efforts, including naloxone distribution, also are essential. Access to naloxone by first responders is a critical component of strategies to combat fatal overdose, but efforts to engage with people who use drugs and their family members or friends may be overlooked by authorities who develop action plans. Awareness and engagement of stakeholders have been effective elements in reducing the number of fatalities. Innovative strategies to get naloxone in the hands of those who would typically be the “first responder” is a critical consideration (e.g., peer recovery services).

4. Listen to local community needs, priorities, and innovative solutions

Community involvement was identified as a key protective factor in reducing overdose deaths. Those in administrative positions may benefit by listening to community members about what is needed and what works, as well as by working to increase community involvement. Collaboration is the key to address overdose deaths.

5. Support cultural solutions

American Indian cultural involvement was seen as a key solution to the opioid crisis; lack of opportunities and historical suppression of cultural practices was seen as contributing to overdose deaths. Traditional approaches are grounded in strengths-based practices guided by inherent Indigenous wisdom and values that have been the source of resiliency for American Indians since time immemorial and have begun to gain recognition by federal authorities as essential elements that require funding and support. Traditional values that underscore the importance of each member of society remind us that each fatality is a relative. There is a need for more funding for these American Indian cultural practices, as well as a need for the ability to bill for cultural practices. When reviewing HotSpot findings, some participants mentioned that cultural practices should not be mandatory. Rather, individuals could choose what religious or spiritual practices they would like to incorporate into their treatment programs, whether that be Christian or American Indian or other. Programs outside of the reservation also may improve outcomes by making culturally-specific services available.

6. Increase funding for opioid treatment and prevention

Indian Health Service continues to be severely underfunded, and increasing this funding would be a key area to impact health inequities and overdose deaths. Tribal communities face challenges to addressing substance use disorder as a result of insufficient resources and provider

shortages. Barriers to seeking treatment for SUD are further complicated when individuals cannot access services because of the increased demand for opioid-related SUD treatment on already overburdened and underfunded systems on reservations. Navigation of the healthcare system for American Indians is only further complicated when individuals have to seek services off the reservation or outside of the tribal health service area where persistent gaps in sharing health records exist.

At the 2018 federal–tribal consultation on opioid use in Prior Lake, Minnesota, one well-respected American Indian provider and researcher discussed how state investment should be distributed according to the rate of disparities. He said, “What was the total investment in the state from grants, how does it align with the rates of disparity? If our tribes are having six to seven times higher disparity, we want a dollar-to-dollar match to address this. When we start to do these types of things, we start to really change the structures in place that perpetuate health inequities.” Beyond substance use disorder treatment, this also includes funding for other services such as Indian Child Welfare because underfunding for these services contributes to ongoing trauma and stress for families.

7. Decrease stigma and shame; increase trust

Shame prevents individuals using opioids from getting help and obtaining what they need for wellness. Training providers to respect individuals using drugs and to meet them where they are at can help to reduce shame and stigma that individuals using drugs feel. This also includes making sure medical and mental health needs of individuals using opioids are met, including having housing available. It also extends to trust of law enforcement and other social/medical/health service providers, as well as community members feeling comfortable calling law enforcement after an overdose. Public media campaigns are one way to address these issues, along with increased training for law enforcement. One idea was to continue a campaign to have a visible sticker in community members’ windows that made it clear it was a safe space to seek support, or that naloxone was available.

8. Improve data collection and access

There are multiple issues related to data access, and many relate to tribal sovereignty. One is whether tribal nations have access to data pertaining to their members, such as autopsy or toxicology reports, or death certificates. Currently they often do not, and may not have the resources to request this or requests are not always granted. Grants and support are needed to build tribal data centers; this could be connected with regional tribal epidemiology centers. Other issues involve the accuracy of death determinations and racial misclassification.

Reliable health-related data also are scarce because of movement of tribal members, which is then further compounded by frequent racial misclassification. Persistent socioeconomic factors such as unemployment and lack of housing resulting from limited resources from federal and state governments are well documented in tribal communities resulting in unique “migratory” patterns of individuals moving between reservations and more urban areas. Additionally, individuals with criminal records face significant barriers to finding employment and housing, which often results in frequent movement between the reservation and urban areas. Not only do these socioeconomic conditions contribute to these trends, cultural factors also play a role in these patterns.

American Indians have a unique political status with the U.S. government. This unique status has a historical context that even precedes the U.S. Constitution. Enrollment requirements in some tribal communities (including the community engaged in this study) are based on social constructions of “blood quantum,” and many tribes provide identification documents that might not be understood or available when a death of a tribal member occurs in an urban area. When an autopsy is performed, there may not be confirmation of the decedent’s enrollment status or tribal affiliation. No national registries are readily available to confirm an individual’s racial/ethnic status, which can be problematic for numerous reasons for American Indians. In addition to these challenges, tribal health authorities do not automatically have access to forensic autopsy reports.

9. Build continuity of care for opioid use disorder

Team members stressed that a collective vision and connected care system for individuals using opioids would help to prevent overdose deaths. In addition, focusing on communication and connections with off-reservation treatment centers as well as with health systems in urban areas and with different tribal nations would improve care for individuals with opioid use disorder. One member highlighted the need for a detoxification facility on the reservation so that fewer individuals would have to leave for this service.

10. Prioritize inter-agency relationship building and collaboration

Jurisdictional issues were highlighted as a barrier to overdose death prevention. White Earth Nation coordinates overdose prevention with a patchwork of counties, the state, and the federal government. This takes time and effort, but when it works well, it can save lives.

11. Address community concern about harm to others

Many community members have safety concerns about being victims of crimes that may be committed by individuals using drugs. Law enforcement could let community members know what they are doing to address this. Addressing this issue would help the whole community unite in supporting individuals with substance use disorder to receive the help they need.

Limitations

This project was a small study to assess the feasibility of conducting OFRs and factors contributing to overdose deaths. Findings may not generalize to other tribal communities and only represent the attitudes of those who participated in the focus groups and the five cases reviewed. Some OFR team members decided not to participate after the first meeting, and we did not survey their views on OFR. The five cases reviewed did not have complete data available, which also limits the accuracy of the findings. However, this was the first pilot of OFR based in a tribal community.

Future Directions

Opioid OFR provides a novel look across healthcare, recovery/addiction services, public safety, and other related systems to identify ways to improve these systems to prevent future overdose deaths. OFR may be a useful strategy within other tribal communities and settings. It provides a contextual examination that can align with Indigenous beliefs about death. Future research should also examine OFR’s potential to contribute to community healing and inform community interventions that address cycles of trauma.

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Appendices

- A. Pre-OFR Focus Group Guide
 - a. OFR team
 - b. Community members
- B. Post-OFR Focus Group Guide
 - a. OFR team
 - b. Community members

Appendix A: Pre-OFR Focus Group Guide

A. OFR team

1. What parts of the fatality review meetings do you think will be especially helpful?
2. What concerns do you have about the OFR process or the meetings?
3. What do you expect we'll find from holding these reviews?
4. What do you think makes the community vulnerable to overdose? What are some of the factors that makes the community vulnerable to overdose?
5. As you think about getting ready for these reviews, what do you think is one area or one question that we should make sure to always be asking at these reviews?
6. From what you know about OFR so far, what fits from an anishinaabe perspective?
7. What could be changed to better fit with cultural values and anishinaabe traditions?
8. What can we do to reduce the amount of stress that you all will feel, or burnout from this process?

B. Community members

1. After you heard about this overdose fatality review, what concerns come to mind about it?
2. Who are the best people to review different cases?
3. What do you see as benefits or things that could be good about it [overdose fatality reviews]?
4. What strengths do you feel that White Earth has that makes the community less vulnerable to overdose? What are some of the protective factors or the good things that are here that protect people against overdose?
5. What do you think makes people vulnerable to overdose here?

Appendix B: Post-OFR Focus Group Guide

A. OFR team

1. What did you find most useful about participating in overdose fatality review?
2. What could be improved about the case review?
3. What changes could be made to the case review process for it to be a better cultural fit?
4. How did you feel after the meetings, and what would make you feel more supported as an OFR team member?
5. Should OFR continue? If no or maybe, then why not?
6. Does anyone have thoughts on how cases should be identified?
7. Were people happy with the cases that you reviewed or are there other approaches to selecting cases?
8. Before we close, any thoughts on what would make OFR sustainable?

B. Community members

1. What are your reactions, positive or negative, and what do you think should happen next at White Earth with fatality review?